DESIGN REPORT OF THE

COMPETITIVE PRICING ADVISORY COMMITTEE

(REVISED)

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TABLE OF CONTENTS

INTRODUCTION

The Balanced Budget Act of 1997 (BBA) establishes a new basis for the Health Care Financing Administration (HCFA) to test competitive pricing for Medicare + Choice organizations.[1] In particular, the statute directs the Department of Health and Human Services (DHHS) to design and implement four competitive pricing demonstrations (one in a rural area), based on the recommendations of a national Competitive Pricing Advisory Committee (CPAC) and of Area Advisory Committees (AACs) at each demonstration site. This explicit statutory mandate follows earlier HCFA efforts to develop and implement competitive pricing designs for Health Maintenance Organizations (HMOs) in Baltimore (1996) and Denver (1997), based on HCFA's general demonstration authority.

The CPAC was appointed in early 1998. It has met five times: in May, June, September, and October, 1998, and January, 1999. At the second CPAC meeting, subcommittees were appointed to examine specific design issues in detail and to make recommendations to the full CPAC. At the third CPAC meeting, these recommendations were debated, and the full CPAC voted on specific design options to recommend to HCFA. Certain other design-related issues were discussed at the fourth CPAC meeting. The design was finalized at the fifth meeting.

Together, the design options the CPAC has recommended to HCFA constitute the basic design for a Medicare Competitive Pricing Demonstration. The CPAC has left some issues to the local AACs – e.g., notably, choices about benefit design, risk selection, and the government contribution, as described below. At the same time, numerous details remain to be fleshed out as the model is implemented. The expectation is that both kinds of decisions will benefit from intimate knowledge of particular demonstration sites, as will be possessed by the AACs. But while there are many decisions remaining to be made, the CPAC design represents defining choices for the demonstration. This paper will summarize those choices, in order to clarify the kind of demonstration that the CPAC has recommended.

This paper is divided into four sections that mirror the general issue areas that the four CPAC subcommittees respectively addressed.

Issue Cluster I: Eligibility And Participation

1. Plan eligibility
2. Plan participation
3. Participation by Medigap insurers
4. The employer role

Issue Cluster II: The Benefit Package

5. Standard or non-standard benefit package?
6. Optional supplementary benefits
7. Mid-cycle adjustments to benefits

1 The term "Medicare + Choice" refers to the expanded set of health plans with which HCFA is authorized to contract, under the Balanced Budget Act of 1997.

Issue Cluster III: the Bidding Process

8. The bidding cycle
9. Pre-bid discussions between HCFA and the health plans
10. The process for reaching agreement
11. The structure of the bid

Issue Cluster IV: the Government Contribution to Premiums

12. Setting the contribution
13. What to do about high and low bids?
14. Risk adjusting payments
15. Incorporating Information about quality into the government contribution formula.

The paper will discuss each of these issues in turn. The CPAC's recommendations on each issue are summarized on Table 1 at the end of this paper.

ISSUE CLUSTER I: ELIGIBILITY AND PARTICIPATION

In theory, a wide variety of plans might submit bids under a Medicare competitive pricing system. The key design question is: which plans? This question implicates such issues as: Which types of plans should be eligible to bid? For those types that are eligible, which plans should be required to bid? How do plans qualify to bid? How should Medigap and employer coverage be treated in the demonstration? These issues are a good way to begin framing the demonstration design.

Design Issue 1 – Plan Eligibility

1. What plan types should be included in the demonstration?

BBA requires that the Competitive Pricing Demonstration be performed for all Medicare+Choice plans. The Medicare+Choice types are: 1) coordinated care plans – i.e., health maintenance organizations (HMOs), point-of-service (POS) plans, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), religious fraternal benefits plans; and other coordinated care plans that meet the Medicare+Choice standards; 2) private fee-for-service plans; and 3) medical savings account (MSA) plans. In addition, beneficiaries can opt to remain in conventional Medicare fee-for-service.

CPAC RECOMMENDATION: All Medicare+Choice plans except MSAs should be included in the demonstration. MSAs require a separate demonstration and should be excluded from the demonstration of competitive pricing.

2. Should conventional fee-for-service be included in the Competitive Pricing Demonstration?

The CPAC discussed whether conventional fee-for-service Medicare should be included in the demonstration. The BBA does not authorize inclusion of fee-for-service in this demonstration.

CPAC RECOMMENDATION: The CPAC was advised that the intent of the demonstration was to develop a pricing methodology for Medicare+Choice organizations only. But the committee urged HCFA to explore the receptivity of Congress to include fee-for-service in the demonstration. The committee also expressed the judgment that the exclusion of fee-for-service might jeopardize the acceptance of the demonstration by Medicare+Choice plans and limit HCFA's ability a) to measure the impact of competitive pricing and b) to generalize demonstration results to the entire Medicare program.

3. Should eligibility be extended to plans that do not meet all HCFA requirements?

In addition to general issues of eligibility, the CPAC considered whether plan types that are otherwise eligible (e.g., HMOs) should be permitted to bid if they fail to satisfy HCFA regulatory requirements.

CPAC RECOMMENDATION: The demonstration should follow standard Medicare practice – i.e., there should be no waiver of requirements that plans must otherwise satisfy to participate in Medicare.

4. Should health plans be fully qualified in order to bid? Or should plans that have received preliminary review for qualification be allowed to bid, as well?

Given its decisions above – concerning which plan types are eligible for the demonstration – the CPAC then reviewed how particular, eligible plans might qualify to bid.

CPAC RECOMMENDATION: The demonstration should allow preliminary review of interested, but not yet qualified, plans. To accomplish preliminary review, HCFA should:

- ***specify in advance an annual date after which new plans that are not fully qualified cannot participate in Medicare and the new pricing methodology.***
- ***review completed, formal application materials from interested plans and give those plans a tentative judgment about whether they are likely to be fully qualified by the specified date.***

Design Issue 2 – Plan Participation

Given a determination of which plans are eligible for the demonstration and how they qualify (see above), the question then becomes whether plans that are eligible *must* participate.

1. Should all eligible plans be required to participate in the demonstration?

The key issue here is whether participation in the demonstration was mandatory or optional. Should there be an alternative payment system available for plans that choose not to submit a bid?

CPAC RECOMMENDATION: All eligible plans not otherwise exempted must participate in the demonstration, in order to participate in Medicare.

2. Should plans participating in other HCFA demonstration projects be excluded from the Competitive Pricing Demonstration?

Plans that are part of current HCFA demonstration projects (SHMO, PACE, CHOICES, etc.) require special attention. These plans are targeted to special populations, but they nonetheless compete, in a limited sense, against HMOs and other "standard" HCFA-sponsored plans for enrollees. If sites are chosen for the Competitive Pricing Demonstration that include these special HCFA demonstration plans (and site selection may take this issue into account), the incorporation of those demonstration plans into the Competitive Pricing Demonstration must be considered.

CPAC RECOMMENDATION: Make case-by-case decisions, after sites are selected.

3. Should any penalty be levied on plans that leave the market, rather than submit bids in the first year of the demonstration?

How should HCFA treat HMOs and other plans that currently serve Medicare beneficiaries, but that choose not to participate in the demonstration? Should those plans be allowed to bid the following year, or should they be excluded from that local market until the demonstration is over? Ordinarily in the Medicare program, any plan that withdraws from a market is excluded from that market for five years.

CPAC RECOMMENDATION: There should be no penalty for plans that choose not to participate in the demonstration.

Design Issue 3 – Participation by Medigap Insurers

1. What is the proper role of Medigap insurers in the demonstration?

The proper role of Medigap plans in the demonstration must be considered, given how enrollment in a managed care plan might affect later Medigap options. There is a question as to what degree Medigap plans should be encouraged or required to participate in the demonstration, at least in terms of providing information.

CPAC RECOMMENDATION: Beneficiaries should be given information about Medigap plans, as part of the special efforts made to inform beneficiaries about their options under any competitive pricing demonstration.

Design Issue 4 – Employer Role

Group retirees are Medicare beneficiaries who obtain their Medicare or Medigap coverage through a former employer. In some cases, the employer may pay all or some of the premiums. Many group retirees receive coverage of extra (non-Medicare covered) benefits through their former employer. The contractual relationship the plan has with an employer is separate from the relationship it has with HCFA. This fact raises two major issues for any Medicare competitive pricing demonstration.

1. Should employers be required to offer the same benefit package as the demonstration?

A first issue is how the benefit package established for the demonstration meshes with established benefit packages for employer groups at demonstration sites. The benefit package on which health plans bid may include a set of standard enhancements – that is, a package of benefits based on the pre-demonstration community norm in the market area. If this enhanced package is more generous than the packages offered by employer groups (or simply different from those employer packages), should employer groups be forced to adopt the enhanced package?

CPAC RECOMMENDATION: Allow employers to continue to offer different benefit packages to their group beneficiaries, even if those packages are less generous than the demonstration benefit package.

2. Should the demonstration grandfather employer-plan agreements?

In any market, employers will have established multi-year contracts with providers, plans, and others. The intrusion of a demonstration into that settled set of arrangements raises a question about whether or not such arrangements should be left undisturbed. This issue raises considerations similar to those concerning the standard benefit, in question 1 immediately above.

CPAC RECOMMENDATION: Employer-plan arrangements are not an issue, since CPAC recommendations allow employers to offer different benefit packages from the demonstration (see recommendations for question 1 immediately above).

ISSUE CLUSTER II: THE BENEFIT PACKAGE

The next set of design questions concern the benefit package on which health plans will bid. Should all plans bid on the same basic benefit package? Should supplementary packages be allowed? Under what circumstances?

Design Issue 5 – Standard or Non-Standard Benefit Package?

The primary concerns here are whether the benefit package should be standardized – and if so, how should the standardized package be established.

1. Should all plans bid on the same package of basic benefits?

In principle, health plans could be allowed to submit bids for any package of benefits of their own design that meets statutory requirements. On the other hand, in view of the need for the government to assess bids across plans and its desire to provide beneficiaries with *comparative* information on managed care alternatives, it may be essential to standardize bids on at least a basic package of benefits.

CPAC RECOMMENDATION: All plans should submit bids on a standard benefit package.

2. If there is a standard benefit package, should it be limited to the basic Medicare entitlement or should it include additional benefits?

If the benefit package is to be standardized for all plans, at what level should the standard benefit be set? The basic choice here concerns whether the Competitive Pricing Demonstration should set the benefit at the level of Medicare statutory entitlement, or at some more comprehensive level.

> ***CPAC RECOMMENDATION: The standard benefit on which all plans bid should be enhanced beyond the statutory entitlement. Specifically, there should be a national minimum standard package composed of the statutory benefit with a limited drug benefit ($500 cap) with cost sharing. Depending upon the local level of benefits, the standard benefit package may include enhancements or additional benefits beyond the national minimum.***

3. If there is a standard benefit package based on an enhanced benefit, should the enhancements be determined according to a local standard or a national standard?

If the benefit package is to be enhanced for all plans as the CPAC has recommended, the question then becomes what standard should be used to establish the enhancements. Many different standards can be imagined, but the most important issues is whether local norms or national standards should apply.

> ***CPAC RECOMMENDATION: Enhancements beyond the national minimum (see above) should be determined according to a local standard. These enhancements may include additional benefits and/or lower cost sharing. The Area Advisory Committees, in consultation with HCFA, should set the enhancements for their respective sites.***

Design Issue 6 – Optional Supplementary Benefits

Optional supplementary benefits are benefit packages other than the package on which plans are required to bid. The full price of all supplementary benefits is paid by the beneficiary. Bids on these supplementary benefits thus do not affect calculation of government payment rates for the standard package. Two major design questions arise.

1. Should optional supplements build on the basic benefit?

The first question about supplements concerns their structure. Must they build upon the basic benefit package on which all plans bid, or can they modify that package?

> ***CPAC RECOMMENDATION: Optional benefits should be offered only as additions to the basic or standard benefit.***

2. Should there be any limitations on the content or number of optional supplementary benefits?

Should there be any other restrictions on the content or number of optional supplements, beyond the limitation that supplements should be add-ons to the basic benefit? The issues here include questions of beneficiary understanding, health plan behavior, administrative burden, and the potential efficiency costs of limitations/regulation.

CPAC RECOMMENDATION: There should be no restriction on the number or type of supplementary benefits that plans can offer. However, HCFA should define each type of supplementary benefit (e.g., vision care, dental care, hearing screening, etc.) with standard language, to make these supplements more easily understood by beneficiaries..

Design Issue 7 – Mid-Cycle Adjustments to Benefits

1. Should health plans be allowed to adjust their benefit packages in between bid cycles?

Should the benefit packages proposed by health plans as part of the bidding process be maintained for the entire bidding cycle, or should these packages be allowed to change in reaction to market pressures? Allowing health plans to reduce the benefit package after bids are received not only might anger beneficiaries, but also could remove any incentive for the plans to submit meaningful bids – bids that must be meaningful insofar as possible, since the government will, in some fashion, base its payments to plans on them. However, in order to compete, plans might want to add benefits to their standard or supplementary benefits.

CPAC RECOMMENDATION: Allow mid-cycle enhancements. After 6 months, give the health plans one opportunity to provide enhanced benefits.

ISSUE CLUSTER III: THE BIDDING PROCESS

The next cluster of issues concerns the bidding process – in effect, how the competitive bidding process should be structured and organized to provide HCFA, the plans, and other stakeholders with the needed framework to obtain market-like prices. There are five design issues to consider.

Design Issue 8 – The Bidding Cycle

1. How long a period should be covered by health plans' bids?

One obvious issue with which to begin is simply the length of the bidding cycle. There is no limit to the possibilities here, but the issue can be framed in terms of two principal alternatives: a one-year cycle versus some longer period.

CPAC RECOMMENDATION: Bidding cycles should be one year.

2. Should the bidding schedule for the demonstration match the Medicare+Choice schedule being implemented under BBA?

Beginning in 1999, HCFA will announce payment rates by March 1. Plans must submit ACR proposals to HCFA by May 1. Final benefit plans must be defined by July 1. The key question for the Competitive Pricing Demonstration is whether or not the demonstration should match this schedule,

especially by providing prices by March 1.

CPAC RECOMMENDATION: HCFA should try to match the BBA schedule as much as possible, but should allow conflicts with BBA schedule if necessary.

Design Issue 9 – PRE-BID Discussions between HCFA and Health Plans

1. What is the optimal way for HCFA and health plans to exchange information before the RFP is issued and while plans are preparing their bids?

One way to minimize the probability of errors on the part of health plans is to allow an exchange of information between HCFA and the health plans prior to the submission of bids. This exchange needs to take place in a way that is helpful to health plans, but does not give one plan an advantage over its competitors. Thus, in any event, it must be a *formal process*, that is resilient against possible post-bidding complaints and legal challenges.

CPAC RECOMMENDATION: HCFA should pursue an active program of information for this solicitiation:

Before the solicitation is issued

In each site, HCFA should utilize the AAC: a) to serve as an advisory group on the bidding process as well as other implementation issues, and b) to coordinate education activities on bidding and, in particular, risk adjustment. Educational sessions should provide any technical assistance to plans that may be required for them to submit accurate bids.

HCFA should hold pre-bid conferences. However, HCFA should not hold private or informal discussions with particular plans.

After the solicitation is issued

HCFA should accept formal written questions and provide written answers to all bidders.

HCFA should hold a Bidder's Conference and should also provide written answers (distributed to all bidders) for any questions raised by bidders after the solicitation is issued. HCFA should not hold private or informal discussions with particular plans.

Design Issue 10 – POST BID: The Process for Reaching Agreement

1. Should HCFA informally interact with health plans after bids are submitted? Or should results of the solicitation be determined from the formal submissions?

Competitive pricing programs in the public and private sectors have different ways of processing the bids received from managed care plans. The public programs tend toward formal processes with fewer opportunities for one-on-one negotiation and exercises of buyer discretion, as that is practiced in the private sector. But even in the private sector, there is substantial variation.

CPAC RECOMMENDATION: HCFA should determine the results of bidding as follows: a) from

formal bids, rather than negotiations; and b) from the first round of bidding. If the bids are unacceptable after the first round, HCFA should reserve the right to request a second round of bids.

Design Issue 11 – The Structure of the Bid

1. Should health plans be required to break their bid down into different levels of bid (e.g., statutory minimum benefit and standard enhancements) and different service components (e.g., inpatient hospital, outpatient physician, etc.)?

The bare essential bid by all participating health plans is a price for the standard benefit package. Plans could be required to break that bid down along at least two dimensions: a) plans could be required to offer a separate price for each component of the benefit (notably, the statutory entitlement and the enhancements); and b) plans could be required to provide an estimate of the cost of major categories of coverage, such as inpatient care, physician services, etc. In addition, if bidders wish to offer any packages of *optional* supplementary benefits, they might be required to provide detailed prices for the major services that make up each package of supplementary benefits.

CPAC RECOMMENDATION: HCFA should require less, rather than more, information. Specifically, HCFA should not require detailed pricing breakdowns on either the components of the benefit or categories of coverage, unless the CPAC determines that such information is required for other aspects of the Competitive Pricing Demonstration (e.g., the evaluation).

2. Should plans be allowed to submit bids for an area larger than the demonstration area?

For any given site, some plans will have service areas that include adjacent counties outside the demonstration area. For a variety of reasons, including marketing convenience, it might be helpful for these plans to be able to establish the same terms across *their* service areas. However, there are competing considerations, concerning how such bids might present opportunities for health plans to game their bids and participation.

CPAC RECOMMENDATION: Plan bids should apply only to the demonstration area.

3. Should plans be required to serve the entire demonstration area?

The demonstration area is likely to be a multi-county area defined by a Metropolitan Statistical Area. Some individual health plans may have service areas in their HCFA contract that include all counties in the demonstration area. Other plans may serve only a portion of the demonstration counties. The question is, do plans have a choice as to how much of the demonstration site they serve? This issue may have a ready answer for incumbent plans (e.g., simply require them to serve at least the counties they previously served). But the answer is not obvious for new entrants.

CPAC RECOMMENDATION: Plans should be permitted to serve less than the entire demonstration area.

4. Should payment levels be set at different levels for different counties in the demonstration area?

Because enrollee costs vary by county, the demonstration design must establish whether health plans

are to submit one bid for a base county (with payments to other counties adjusted in some fashion), a separate bid for each county in a demonstration area, or one bid for the entire demonstration area. This is a consideration in how the bids will be structured. It is also a consideration of risk adjustment (see Design Issue 14 below), since failure to adjust payments to reflect higher costs in some counties could have the same discriminatory effects as failure to adjust for any other cost factor.

CPAC RECOMMENDATION: Once the county configuration is known for the demonstration area, the AAC should recommend whether plans: a) submit bids on one base county (with payments adjusted for other counties), or b) submit separate bids on each county. In making this determination, the AAC should consider how each plan's service area is defined and how enrollment is distributed across the demonstration counties.

ISSUE CLUSTER IV: THE GOVERNMENT CONTRIBUTION TO PREMIUMS

The final cluster of design issues concerns the government contribution to premiums: the method used to set the contribution, the incentives that the method provides for plans to submit market-level bids, the techniques used to risk adjust payments, and the extent to which quality and other issues are taken into account.

Design Issue 12 – Setting the Contribution

1. How should HCFA set the government's contribution to premiums?

After HCFA receives the HMOs' bids for the basic package of benefits, HCFA must determine the government's contribution to premiums or "cutoff price." There are many different ways to do this.[2] Each of these methods has different implications – for plan behavior (e.g., the strength of the incentive for plans to submit low bids), for the risk of large shifts in beneficiary payment terms (e.g., how many beneficiaries who were not paying a premium before the demonstration might have to pay a premium during the demonstration), and other issues.

CPAC RECOMMENDATION: The AAC should choose between two options: (1) the median bid (adjusted to reflect available capacity in low bid plans); or (2) the enrollment weighted average bid (based on the prior year's Medicare risk or Medicare+Choice enrollment). HCFA should make sure that each method is used in at least one demonstration site.

The CPAC believes that permitting budget neutrality over the entire demonstration (rather than requiring <u>each site</u> to have budget-neutral results) would provide a more robust demonstration,

2 For example, HCFA could set its contribution at the level of the lowest bid received from a qualified plan, the second lowest bid received from a qualified plan, a percentile of all bids (e.g., the median bid), a fixed percentage above the lowest bid (e.g., 110 percent of – that is, 10% *higher* than – the lowest bid), an enrollment-weighted average of all bids, a "comfort level" (i.e., a discretionary choice of cutoff point determined *after* the bids are received), a fixed percentage of each bid (e.g., pay all plans 75% of their respective bids).

by making it more attractive to high- and low-AAPCC areas.

2. Should the method for setting the government contribution be based on a formal rule, announced in advance?

An issue in the Denver demonstration concerned whether HCFA should commit in advance – and announce to the plans – a *specific formal rule* for setting the government contribution.

CPAC RECOMMENDATION: The government contribution should be based on a formal rule, announced in advance.

Design Issue 13 – What to Do about High and Low Bids?

1. What should be the incentives – the rewards and penalties – to encourage plans to bid low?

There must be *some penalty* associated with high bids, in order to provide plans an incentive for plans to bid close to their costs. Similarly, there should be *some reward* for bids that are low, or below the cutoff price, in order to encourage plans to bid low. The important design question is to decide what balance of penalties and rewards is right for encouraging economical bids. The potential options are innumerable – given any list of options, it is always possible to imagine a new and different kind of penalty or reward.

CPAC RECOMMENDATION: Plans bidding above the government cutoff should not be excluded from the Medicare program. The excess of their bids over the cutoff should be converted to a beneficiary premium. Plans bidding below the government cutoff should all be paid at the cutoff rate and allowed to retain the difference or to add benefits worth the difference. HCFA should review the additional benefits.

Design Issue 14 – Risk Adjustment

Failure to adjust payments to health plans for the expected cost of beneficiaries will result in discrimination against high-cost enrollees (because, without risk adjustment, plans have greater incentive to manipulate the enrollment and disenrollment processes to avoid high-cost enrollees). In a competitive pricing system with inadequate risk adjustment, the possibility arises of "death spirals" for plans enrolling high risk beneficiaries – an important change from the concerns about cream-skimming under the current administrative pricing system. There are at least two important questions to consider.[3]

1. How should HCFA risk-adjust its payments to health plans?

Granting the need for some kind of risk adjustment, how should it be done? Note that this is an area of considerable movement in the standard Medicare program. Medicare capitation payments are now adjusted using demographic factors (age, sex, working aged, institutional status, and Medicaid eligibility). By January 2000, HCFA is required by the BBA to convert the risk adjustment system to health status

3 A third, related issue – the adjustment of payments for variation in county costs – is discussed above under Design Issue 11 – The Structure of the Bid.

factors, based on the Principal In-Patient (PIP) Diagnostic Cost Group (DCG) model.

CPAC RECOMMENDATION: Health plans should submit bids on a baseline "1.0" beneficiary. Risk adjustment should be done using the same methods employed in non-demonstration sites, but the AACs should have the flexibility to choose between two types of deviations for their respective sites:

- ***keep the "old" system in year one – If non-demonstration sites are implementing new, health-based methods of risk adjustment, the AAC could choose for year one to waive these changes and keep the old, demographic-based system of risk adjustment. The site would then implement the new system of risk adjustment in year two.***

- ***adopt special risk adjustment systems for chronically ill or other subpopulations – The AAC may propose alternative risk adjustment factors or demographic/condition-specific multiples more appropriate for the chronically ill or other sub-populations, based on the proposals of local plans.***

With respect to the second option, HCFA should set deadlines for such proposals at each site. The final decision to implement any special risk adjustment systems should be contingent upon HCFA's ability to administer the alternative methodology.

2. Should beneficiary out-of-pocket premiums vary by the beneficiary's risk?

If the government contribution is risk adjusted, the question arises as to how beneficiary premiums should be calculated. There are many different possible approaches – for example, beneficiary premiums could also be risk adjusted; or all beneficiaries could pay the same, average premium.

CPAC RECOMMENDATION: For each plan, enrollees in all risk categories should pay the same premium.

Design Issue 15 – Taking Quality into Account

A final design issue reviewed by the CPAC concerns how quality should be taken into account in the demonstration. This raises a large series of issues, that may be considered in terms of one general question.

1. What methods are available to encourage health plans to offer higher quality care?

Concern over quality is not unique to the Competitive Pricing Demonstration, but extends to care in the current managed care system and in the traditional fee-for-service Medicare sector as well. There are several levels on which the issue of quality can be addressed in the Competitive Pricing Demonstration. The first, and most important, remains HCFA's health plan qualification process. If the qualification process works well, health plans offering poor quality of care would not be offered to beneficiaries at all. Beyond this basic rule, however, should HCFA design an explicit system of rewards for health plans that offer higher quality care, or should HCFA focus its efforts on providing information about quality to consumers and leave consumers to "reward" health plans with increased enrollment?

CPAC RECOMMENDATION: HCFA generally should follow current Medicare practice for the early years of the demonstration – specifically, HCFA should rely on the plan qualification

process and retail competition among plans (and should consider using existing accreditation agencies such as NCQA or JCAHO) to ensure the quality of care of health plans. In addition, HCFA should provide the CPAC with more information on what measures are available to use in measuring plan quality of care, and how these measures could be used in the out years of the demonstration to create an incentive pool for high quality plans (e.g., by withholding a small percentage of savings to create the pool and distributing it among plans, based on the achievement of quality goals).

Table 1. Summary of Recommendations of the Competitive Pricing Advisory Committee

ISSUE CLUSTER	DESIGN ISSUE	QUESTION	CPAC RECOMMENDATION
I. ELIGIBILITY AND PARTICIPATION			
	Design Issue 1 – Plan Eligibility		
		1. What plan types should be included in the demonstration?	All Medicare+Choice plans, except MSAs.
		2. Should conventional fee-for-service be included in the Competitive Pricing Demonstration?	The CPAC was advised that the intent of the demonstration was to develop a pricing methodology for Medicare+Choice organizations only. But HCFA should explore Congress' receptivity to including fee-for-service, as the demonstration may otherwise face problems of plan acceptance and be difficult to evaluate and generalize.
		3. Should eligibility be extended to plans that do not meet all HCFA requirements?	Follow standard Medicare practice – i.e., no waiver of requirements that plans must otherwise satisfy to participate in Medicare.
		4. Should health plans be fully qualified in order to bid?	Allow preliminary review of interested, but not yet qualified, plans. But set date by which plans must fully qualify, in order to participate.
	Design Issue 2 – Plan Participation		
		1. Should all eligible plans be required to participate in the demonstration?	Participation mandatory, unless plan is otherwise exempted.
		2. Should plans participating in other HCFA demonstration projects be excluded from the Competitive Pricing Demonstration?	Make case-by-case decisions, after site is selected.
		3. Should any penalty be levied on plans that leave the market?	No penalty for choice not to participate.
	Design Issue 3 – Participation by Medigap Insurers		
		1. What is the proper role of Medigap insurers in the demonstration?	Beneficiaries should be given information about Medigap plans, as part of the special demonstration efforts to inform beneficiaries.
	Design Issue 4 – Employer Role		
		1. Should employers be required to offer the same benefit package as the demonstration?	Allow employers to continue to offer different benefit packages to their group beneficiaries, even if those packages are less generous than the demonstration package.
		2. Should the demonstration grandfather employer-plan agreements?	Employer-plan arrangements are not an issue, since CPAC recommendations allow employers to offer different benefit packages from the demonstration.
II. THE BENEFIT PACKAGE			
	Design Issue 5 – Standard or Non-Standard Benefit Package?		
		1. Should all plans bid on the same package of basic benefits?	Yes.

ISSUE CLUSTER	DESIGN ISSUE	QUESTION	CPAC RECOMMENDATION
		2. Should the standard package be limited to the basic Medicare entitlement or should it include additional benefits?	The standard benefit should be enhanced beyond the statutory entitlement; and there should be a national minimum standard package composed of the statutory benefit with a limited drug benefit ($500 cap) with cost sharing. Depending upon the local level of benefits, the standard benefit package may include enhancements or additional benefits beyond the national minimum.
		3. Should the enhancements be determined according to a local standard or a national standard?	Enhancements beyond the national minimum (see above) should be determined according to a local standard. AACs, in consultation with HCFA, should set the enhancements for each site.
	Design Issue 6 – Optional Supplementary Benefits		
		1. Should optional supplements build on the basic benefit?	Optional supplements should be offered only as additions to the basic benefit.
		2. Should there be any limitations on the content or number of optional supplementary benefits?	No limitation on number or type of optional supplements. But HCFA should standardize the language used to describe these benefits.
	Design Issue 7 – Mid-Cycle Adjustments to Benefits		
		1. Should health plans be allowed to adjust their benefit packages in between bid cycles?	Mid-cycle adjustments allowed to enhance benefit packages.
III. THE BIDDING PROCESS			
	Design Issue 8 – The Bidding Cycle		
		1. How long a period should be covered by health plans' bids?	One year.
		2. Should the bidding schedule for the demonstration match the Medicare+Choice schedule being implemented under BBA?	Match schedule, insofar as possible. But allow conflicts if necessary.
	Design Issue 9 – PRE-BID: Discussions between HCFA and Plans		
		1. What is the optimal way for HCFA and health plans to exchange information before the RFP is issued and while plans are preparing their bids?	Before the solicitation is issued: Utilize the AAC: a) to advise on the bidding process/other implementation issues, and b) to coordinate education activities on bidding and, in particular, risk adjustment. Educational sessions should provide technical assistance to plans. Pre-bid conferences with all plans, but no private conferences with particular plans. After the solicitation is issued: Accept formal written questions and provide written answers to all bidders. Hold a Bidder's Conference and provide written answers (distributed to all bidders) for any questions raised by bidders after the solicitation is issued. No private or informal discussions with particular plans.
	Design Issue 10 – POST-BID: The Process for Reaching Agreement		
		1. Should results of the solicitation be determined from the formal submissions? Informal interactions?	Determine the results of bidding from formal bids, rather than negotiations, in first round of bidding. But reserve the right to request a second round of bids, if first-round bids unacceptable.

ISSUE CLUSTER	DESIGN ISSUE	QUESTION	CPAC RECOMMENDATION
	Design Issue 11 – The Structure of the Bid		
		1. Should health plans be required to break their bid down into different levels of bid and different service components?	Require less, rather than more, information. Do not require detailed pricing breakdowns on either the components of the benefit or categories of coverage, unless the CPAC determines that such information is required (e.g., for the evaluation).
		2. Should plans be allowed to submit bids for an area larger than the demonstration area?	Bids should apply only to the demonstration area.
		3. Should plans be required to serve the entire demonstration area?	No.
		4. Should payment levels be set at different levels for different counties in the demonstration area?	The AAC should recommend whether plans submit bids: a) on one base county (with payments adjusted for other counties), or b) on each county. AAC should take account of service areas of plans and distributions of enrollment.
IV. THE GOVERNMENT CONTRIBUTION TO PREMIUMS			
	Design Issue 12 – Setting the Contribution		
		1. How should HCFA set the government's contribution to premiums?	The AAC should choose either of two rules: a) the median bid (adjusted to reflect available capacity in low bid plans); or (2) the enrollment weighted average bid (based on the prior year's Medicare risk or Medicare+Choice enrollment). Each method should be used in at least one demonstration site. If budget neutrality were permitted over the entire demonstration rather than particular sites, a more robust demonstration would result, as it would make the demonstration more attractive to high- and low-AAPCC areas.
		2. Should the method for setting the government contribution be based on a formal rule, announced in advance?	Yes.
	Design Issue 13 – What to Do about High and Low Bids?		
		1. What should be the incentives – the rewards and penalties – to encourage plans to bid low?	Plans bidding above the government cutoff: excess of bids over the cutoff should be converted to a beneficiary premium. Plans bidding below the government cutoff: all should be paid at the cutoff rate and allowed to retain the difference or to add benefits worth the difference.
	Design Issue 14 – Risk Adjustment		

ISSUE CLUSTER	DESIGN ISSUE	QUESTION	CPAC RECOMMENDATION
		1. How should HCFA risk-adjust its payments to health plans?	Health plans should submit bids on a baseline "1.0" beneficiary. Use then-current Medicare risk adjustment methods, unless AAC chooses either: • to keep the old (demographic-based) risk adjustment in year one of the demonstration, with implementation of any new HCFA method of risk adjustment thereafter; or • alternatives proposed in a timely way by the AAC for the chronically ill or other sub-populations, so long as HCFA determines it can administer such alternatives.
		2. Should beneficiary out-of-pocket premiums vary by the beneficiary's risk?	For each plan, enrollees in all risk categories should pay the same premium.
	Design Issue 15 – Taking Quality into Account		
		1. What methods are available to encourage health plans to offer higher quality care?	Early years of the demonstration: Follow current Medicare practice – rely on the plan qualification process and retail competition among plans (and consider using existing accreditation agencies such as NCQA or JCAHO) to ensure the quality of care of health plans. Out years: HCFA should provide the CPAC with additional information on what measures are available to use in measuring plan quality of care, and how these measures could be used to create an incentive pool for high quality plans.